State of Connecticut
Office of Health Care Access
Letter of Intent/ Waiver Form (2030)

All applicants must complete a Letter of Intent (LOI) form prior to submitting a Certificate of Need application, pursuant to Sections 19a-638 and 19a-639 of the Connecticut General Statutes and Section 19a-160-64a of OHCA's Regulations. Applicants should submit this form to the Commissioner of the Office of Health Care Access, 410 Capitol Avenue, MS# 13HCA, P.O. Box 340308, Hartford, Connecticut 06134-0308.

SECTION I. APPLICANT INFORMATION

If more than two Applicants, please attach a separate sheet of paper and provide additional information in the format below.

	Applicant One	Applicant Two
Full legal name	LMG Programs, INC	
DBA (Doing Business As)	n/a	
Name of Parent Corporation	n/a	
Mailing Address, if Post Office Box, include a street mailing address for Certified Mail	159 Colonial Rd Stamford, CT 06906	
Applicant type (e.g., profit/ non-profit)	Non-Profit	
Contact person, including title or position	Cary Ostrow VP of Quality Systems	
Contact person's street mailing address	Same as above	
Contact person's phone #, fax # and e-mail address	203-325-1511, F:203-325-4936 cary.ostrow@lmgprograms.org	

SECTION II. GENERAL APPLICATION INFORMATION

Proposal/Project Title: **Termination of Women In Need Program**

Type of Proposal, please check all that apply:

☐ Change in Facility (F), Service (S) or Function (Fnc) pursuant to Section 19a-638, C.G.S.

☐ New (F, S, Fnc)	☐ Replacement	☐ Additional (F, S, Fnc)
☐ Expansion (F, S, Fnc)	☐ Relocation	☒ Service Termination
☐ Bed Addition	☐ Bed Reduction	☐ Change in Ownership or Control

☐ Capital Expenditure pursuant to Section 19a-639, C.G.S.
- ☐ Project cost greater than $ 1,000,000
- ☐ Equipment Acquisition greater than $ 400,000
  - ☐ New ☐ Replacement ☐ Major Medical
  - ☐ Imaging ☐ Linear Accelerator
- ☐ Change in ownership or control, pursuant to Section 19a-639 C.G.S., resulting in a capital expenditure over $1,000,000

Location of proposal (Town including street address): 929 Newfield Ave, Stamford, CT 06905

List all the municipalities this project is intended to serve: Lower Fairfield County

Estimated starting date for the project: July 1st, 2005

Type of Entity: (Please check E for Existing and P for Proposed in all boxes that apply)

E	P		E	P		E	P	
☐	☐	Acute Care Hospital	☐	☐	Imaging Center	☐	☐	Cancer Center
☒	☐	Behavioral Health Provider	☐	☐	Ambulatory Surgery Center	☐	☐	Primary Care Clinic
☐	☐	Other (specify): (E)_____			(P)_____			

Type of project: _____ **(Fill in the appropriate number(s) from page 4 of this form)**

Number of Beds (to be completed if changes are propsed)

Type	Existing Staffed	Existing Licensed	Proposed Increase (Decrease)	Proposed Total Licensed
45	14	14	(14)	0

SECTION III. ESTIMATED CAPITAL EXPENDITURE INFORMATION

Estimated Total Capital Expenditure: $0

Please provide the following breakdown as appropriate:

Renovations	$
New Construction	$
Fixed Equipment	$
Movable Equipment	$
Fair Market Value of Leased Space	$
Fair Market Value of Leased Equipment	$
Other	$

Note: The aggregate of all categories should equal the estimated total capital expenditure.
"Other" includes any category not listed above, (e.g., land acquisition, service agreement, fees, etc.)

Major Medical equipment acquisition:

Unit Type	Model	Name	Number of Units	Cost

Type of financing or funding source (more than one can be checked):

☐ Applicant's Equity ☐ Lease Financing ☐ Conventional Loan
☐ Charitable Contributions ☐ CHEFA ☐ Grant Funding
☐ Other (specify): _____

SECTION IV. PROJECT DESCRIPTION

Please attach a separate 8.5" X 11" sheet(s) of paper and provide no more than a 2 page description of the proposed project, highlighting all the important aspects of the proposed project. Please be sure to address the following:

1. What are the anticipated payer sources?
2. Identify any unmet need and how this project will fulfill that need.
3. What is the effect of this project on the health care delivery system in the State of Connecticut?
4. Are there any similar existing providers in the proposed geographic area?
5. Why should this project be approved?
6. Who will be responsible for providing the service?
7. Who is the target population?

If requesting a Waiver of a Certificate of Need, please complete Section V.

SECTION V. WAIVER INFORMATION

I may be eligible for a waiver from the Certificate of Need process because of the following: (Please check all that apply)

☐ This request is for Replacement Equipment
- ☐ The original equipment was authorized by the Commission/OHCA in Docket Number: _____
- ☐ The cost of the equipment is not to exceed $2,000,000
- ☐ The cost of the replacement equipment does not exceed the original cost increased by 10% per year.

Please complete the attached affidavit.

For Office Use Only:

Action taken:

☐ Waiver Approved ☐ Waiver Denied
☐ Appropriate Forms Sent List of the forms sent: _____

LMG

Saving Lives from Drugs and Alcohol

TERMINATION OF SERVICES FOR THE WOMEN IN NEED PROGRAM

Section IV

1. What are the anticipated payer sources?

   N/A

2. Identify any unmet need and how this project will fulfill that need.

   N/A

3. What is the effect of this project on the health care delivery system in the State of Connecticut?

   The Women In Need Program is funded solely by Court Supported Services Department (CSSD). The CSSD will be putting these 14 beds up for bid and the women will be relocated to another program.

   LMG will not be submitting a bid due to several factors:
   - Increasingly, the women are from outside our catchment area. Consequently, the initial program philosophy of a community-based treatment facility is no longer viable. Family members have difficulty attending sessions. Therefore, the needed support systems are not in place at time of discharge. Clients are not available for aftercare as they return to their home area. Finally, for those women who do want to stay in the area, affordable housing is not available.
   - Clients are entering treatment with an increasing amount of psychiatric needs that a substance abuse facility is not equipped to handle. Medication management, a full-time staff psychiatrist and ongoing treatment issues are beyond the scope of a residential facility without a mental health license.
   - The average daily census has been steadily declining over the course of the year. Due to the issues stated above, clients who do enter treatment are leaving early
   - Cost of providing services rising rapidly while payment stagnant
   - Hiring and maintaining staff willing to work overnight and weekend hours is extremely difficult

4. Are there any similar existing providers in the proposed geographic area?

   - CSSD has other options throughout CT

5. Why should this project be approved?

- LMG cannot afford to continue to run this residential facility. CSSD will place the clients in other facilities

6. Who will be responsible for providing the service?

   - N/A

7. Who is the target population?

   - Women in the judicial system who have a substance abuse problem

STATE OF CONNECTICUT

OFFICE OF HEALTH CARE ACCESS

M. JODI RELL
GOVERNOR

CRISTINE A. VOGEL
COMMISSIONER

April 21, 2005

Mr. Cary Ostrow
Vice President of Quality Systems
LMG Programs, Inc.
159 Colonial Rd.
Stamford, CT 06906

Re: Letter of Intent, Docket Number 05-30479
LMG Programs, Inc.
Termination of Women In Need Program
Notice of Letter of Intent

Dear Mr. Ostrow:

On April 14, 2005, the Office of Health Care Access ("OHCA") received the Letter of Intent ("LOI") Form of LMG Programs, Inc. ("Applicant") for the termination of Women In Need Program, at a total capital expenditure of $0.

A notice to the public regarding OHCA's receipt of a LOI was published in *The Advocate* pursuant to Section 19a-638 of the Connecticut General Statutes. Enclosed for your information is a copy of the notice to the public.

Sincerely,

Susan Cole England

Susan Cole England, Director
Certification, Financial Analysis and Forecasting

SCE:bko